

OMENTAL TROPHOBLASTIC IMPLANT WITH HEMOPERITONEUM AS A SEQUELA OF SUCTION DILATATION AND CURETTAGE

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Omental pregnancy is an extremely rare form of ectopic pregnancy [1]. The diagnosis is usually made during laparotomy [2]. Only 18 cases have been reported in the literature, and most of these were secondary omental pregnancies, following videolaparoscopic surgery for tubal pregnancies, during which the ectopic gestational tissue was expelled from the fimbria and reimplanted itself into the peritoneal cavity [2,3]. We present a case of secondary omental pregnancy as a sequela of suction dilatation and curettage. To the best of our knowledge, this is the first case of an omental pregnancy ever reported as a consequence of iatrogenic uterine perforation.

A 23-year-old nulliparous single woman was admitted to the emergency department of Mackay Memorial Hospital at Hsin Chu with a complaint of abdominal pain. The patient had undergone suction dilatation and curettage for elective termination of a pregnancy 19 days prior to presentation. The uterus was perforated during the operation with subsequent internal bleeding, and emergent laparotomy was performed to repair the wound. At presentation, physical examination revealed diffuse abdominal tenderness and distension, with signs of peritonitis. The patient's blood pressure was 113/60 mmHg and her pulse rate was 102 beats/minute. Her serum hemoglobin, hematocrit and leukocyte levels were 7.9 g/dL, 23% and 7,800/ μ L, respectively, and her serum β -human chorionic gonadotropin (β -hCG) level was 41,535 mIU/mL. On gynecologic examination, the uterus was normal in size and there was no cervical motion tenderness or adnexal tenderness. Transvaginal and abdominal ultrasonography

revealed a large amount of intra-abdominal fluid with no visible intrauterine gestational sac or adnexal mass.

Owing to suspected ectopic pregnancy with hemo-peritoneum, emergent laparotomy was performed. Upon entering the pelvic cavity, both fallopian tubes were found to be normal in appearance. The omentum was found adhering to the scar of a recent uterine perforation. A 3 \times 3 cm bleeding mass was noted on the greater omentum, and partial omentectomy was performed. A total of 1,300 mL of blood was noted in the peritoneal cavity. During the operation, four units of packed red blood cells and two units of whole blood were transfused. A reduction in serum β -hCG to 21,493 mIU/mL was observed the following day. The postoperative course was smooth, and the patient was discharged on the third postoperative day.

Microscopically, the resected omentum showed a coating of recently coagulated blood clots, as well as multiple deposits of gestational tissue containing chorionic villi (many as hydropic villi) and hemorrhagic trophoblasts (Figure). A small patch of endometrial tissue

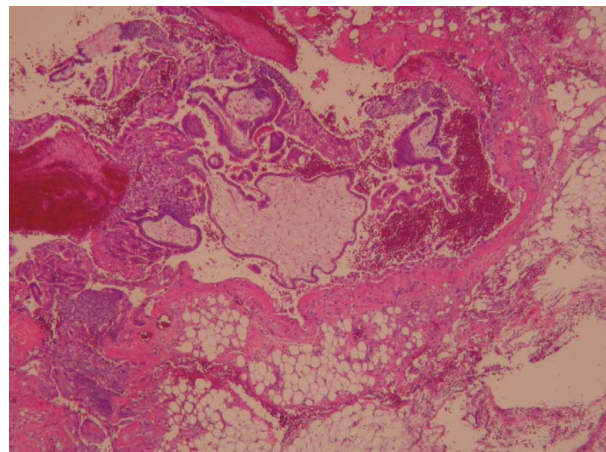


Figure. The deposit of gestational tissue over the omentum contained hydropic chorionic villi and hemorrhagic trophoblasts (hematoxylin and eosin, 80 \times).



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showing decidual changes was also noted, attached to the omentum, while tissue reactions associated with pregnancy were present in the involved omentum.

We believe that, in this case, the omental pregnancy was iatrogenically implanted when the uterus was perforated during suction dilatation and curettage. The omental adhesion to the perforation scar might have provided a mechanism for neovascularization and for sustenance of the parasitic trophoblast. Postoperative surveillance after perforation of the uterus is extremely important, as trophoblastic implants can persist and grow in unusual locations. Patients should be closely monitored, and serial serum β -hCG levels should be

measured to ensure the absence of persistent trophoblastic implants.

References

1. Atrash HK, Friede A, Hogue CJR. Abdominal pregnancy in the United States: frequency and maternal mortality. *Obstet Gynecol* 1987;69:333-7.
2. Onan MA, Turp AB, Saltik A, Akyurek N, Taskiran C, Himmetoglu O. Primary omental pregnancy: case report. *Hum Reprod* 2005;20:807-9.
3. Karaer O, Ilkgül O, Oruç S. Primary omental pregnancy on the gastrocolic ligament. *South Med J* 2007;100:403-4.